



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HEALTHTRUST LLC  
PO BOX 890008  
HOUSTON TX 77289

#### **Respondent Name**

AMERICAN CASUALTY CO OF READING PA

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-11-4759-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Non-responsive by Gallagher Bassett same dispute over responsibility of Universal Smart Corp."

On December 28, 2011, the Division contacted the requestor to verify the services remained in dispute. The requestor verified that dates of service September 20, 2010 and September 21, 2010 were paid in full and no longer in dispute. The requestor stated that for date of service September 17, 2010, the respondent had paid half and still owed \$400.00.

**Amount in Dispute:** \$400.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Carrier has paid per the attached. Carrier maintains its position as outlined in the original response."

"On dates of service 9/17/10, 9/20/10 and 9/21/10 the bills were reprocessed and an additional 800.00 per date of service. The checks were not sent directly to Health Trust, but they were sent to Smart Comp, LLC. The check for DOS 9/17/10 for \$800.00 (no check # yet as it is still pending) was issued 9/27/10 and will be mailed out 9/28/10."

**Response Submitted by:** American Home Assurance Co., FOL, P.O. Box 201329, Austin, TX 78720

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2010	Chronic Pain Management – CPT code 97799-CP (8 hours)	\$400.00	\$400.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits (No date)

- BL-This charge was reviewed through the clinical validation program.
- BL-Your Smartcomp contract requires billing be sent to Universal Smartcomp.
- BL-To avoid duplicate bill denial; for all recon/adjustment/additional pymnt request submit a copy of this EOR or clear notation that a recon is requested.

Explanation of benefits (No date)

- BL-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
- BL-Additional allowance is not recommended as the claim was paid in accordance with state guidelines, usual and customary policies, or the provider's PPO contract.

## **Issues**

1. Did the respondent support position that a PPO contract exists in this dispute?
2. Did the respondent support payment was made in accordance with state guidelines?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The respondent raised the issue of a PPO contract on the explanation of benefits. The requestor states in the position summary that "HealthTrust does not have a contract with Universal Smart Comp granting Universal the rights to audit our multi-disciplinary chronic pain management program,"  
  
A review of the explanation of benefits denotes a \$0.00 PPO reduction was taken. The Division finds that the documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services in dispute will be reviewed in accordance with applicable Division rules and guidelines.
2. The respondent states in the position summary that "On dates of service 9/17/10, 9/20/10 and 9/21/10 the bills were reprocessed and an additional 800.00 per date of service. The checks were not sent directly to Health Trust, but they were sent to Smart Comp, LLC. The check for DOS 9/17/10 for \$800.00 (no check # yet as it is still pending) was issued 9/27/10 and will be mailed out 9/28/10."

The Division contacted the requestor on December 28, 2011 to verify this payment. The requestor stated for date of service September 17, 2010, the respondent had paid half and still owed \$400.00.

The Division finds that the respondent did not submit documentation to support position that payment of \$800.00 was issued to the requestor for the disputed chronic pain management in accordance with the state guidelines. Therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for eight (8) units. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour (\$125.00 X 80%). \$100.00 times the eight hours billed is \$800.00. The requestor stated payment of \$400.00 was received; therefore, the difference between the MAR and amount paid is \$400.00. This amount is recommended for additional reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$ 400.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	12/28/2011
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**